PRINTED: 07/09/2009 FORM APPROVED Bureau of Health Care Quality & Compliance STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X3) DATE SURVEY (X2) MULTIPLE CONSTRUCTION AND PLAN OF CORRECTION COMPLETED **IDENTIFICATION NUMBER:** A. BUILDING B. WING NVS358AGC 06/23/2009 STREET ADDRESS, CITY, STATE, ZIP CODE NAME OF PROVIDER OR SUPPLIER 8460 RANCHO DESTINO RD SAN VICENTE HOME CARE LAS VEGAS, NV 89123 SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION (X4) ID ID (X5) COMPLETE (EACH DEFICIENCY MUST BE PRECEDED BY FULL (EACH CORRECTIVE ACTION SHOULD BE **PREFIX PREFIX** DATE REGULATORY OR LSC IDENTIFYING INFORMATION) CROSS-REFERENCED TO THE APPROPRIATE TAG TAG DEFICIENCY) Y 000 **Initial Comments** Y 000 The findings and conclusions of any investigation by the Health Division shall not be construed as prohibiting any criminal or civil investigations, actions or other claims for relief that may be available to any party under applicable federal, state, or local laws. This Statement of Deficiencies was generated as a result of an annual State Licensure survey conducted in your facility on 06/23/09. This State Licensure survey was conducted by the authority of NRS 449.150, Powers of the Health Division. The facility is licensed for 10 Residential Facility for Group beds which provide care to persons with Alzheimer's disease, Category II residents. The census at the time of the survey was ten. Ten resident files were reviewed and four employee files were reviewed. One discharged resident file was reviewed. The facility received a grade of D. The following deficiencies were identified: Y 103 Y 103 449.200(1)(d) Personnel File - NAC 441A SS=F NAC 449,200 1. Except as otherwise provided in subsection 2. a separate personnel file must be kept for each

If deficiencies are cited, an approved plan of correction must be returned within 10 days after receipt of this statement of deficiencies.

TITLE

(X6) DATE

This Regulation is not met as evidenced by: Based on record review on 6/23/09, the facility

member of the staff of a facility and must include: (d) The health certificates required pursuant to chapter 441A of NAC for the employee.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER IDENTIFICATION NUM			(X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SURVEY COMPLETED		
NVS358AGC		NVS358AGC		B. WING		06/23/2009	
NAME OF PR	OVIDER OR SUPPLIER		STREET ADDI	RESS, CITY, STA	ATE, ZIP CODE	•	
SAN VICE	NTE HOME CARE			CHO DESTINO S, NV 89123	RD		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)			ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	RRECTIVE ACTION SHOULD BE CO ERENCED TO THE APPROPRIATE	
Y 103	Continued From page	2 1		Y 103			
	failed to ensure 2 of 5 caregivers complied with NAC 441A.375 regarding tuberculosis testing (Employee #1, and #5)						
	Severity: 2 Scop	erity: 2 Scope: 3					
Y 105 SS=C 449.200(1)(f) Personnel File - Background Check			heck	Y 105			
	a separate personnel member of the staff of	e provided in subsection file must be kept for ea f a facility and must inc iance with NRS 449.17	ach lude:				
	Based on record reviet failed to ensure 4 of 5 checks completed (Er	rprints, #4 fingerprints a #5 fingerprints, state background).	ity round				
Y 172 SS=C	449.209(2) Health and garbage	d Sanitation-Outside		Y 172			
	the facility must be ke must be covered in su are unable to get insid		nts east				

		(X1) PROVIDER/SUPPLIER/GIDENTIFICATION NUMB		(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING		(X3) DATE SURVEY COMPLETED			
NVS358AGC			B. WING			06/2	23/2009		
NAME OF PROVIDER OR SUPPLIER SAN VICENTE HOME CARE			STREET ADDRESS, CITY, STATE, ZIP CODE 8460 RANCHO DESTINO RD LAS VEGAS, NV 89123						
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Y 172	Continued From page	e 2		Y 172					
	Based on observation	•							
Y 179 SS=C 449.209(6) Health and Sanitation-Screens				Y 179					
	Based on observation	ot met as evidenced by n on 6/23/09, the facility 0 of 10 windows were							
	Severity: 1 Scope:	3							
Y 320 SS=D	449.220(1) Bedroom	Doors - Locks		Y 320					
	equipped with a lock motion from the insid	a residential facility who must open with a single e unless the lock provide and can be operated special knowledge.	e						
		ot met as evidenced by n on 6/23/09, the facility							

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SURVEY COMPLETED	
		NVS358AGC		B. WING		06/2	3/2009
NAME OF PROVIDER OR SUPPLIER			STREET ADDR	RESS, CITY, STA	TE, ZIP CODE		0,2000
SAN VICENTE HOME CARE				HO DESTINO S, NV 89123	RD		
(X4) ID PREFIX TAG	SUMMARY ST. (EACH DEFICIENC REGULATORY OR I	l l	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPR DEFICIENCY)	(X5) COMPLETE DATE		
Y 320	Continued From page	e 3		Y 320			
	failed to ensure single motion locks on 1 of 6 bedroom doors (Bedroom #6).						
	Severity: 2 Scope:						
Y 356 SS=E	449.222(6) Bathroom	s and Toilet Facilities		Y 356			
	NAC 449.222 6. Bathroom doors that are equipped with locks must open with a single motion from the inside without the use of a key. If a key is required to open a lock from outside the bathroom, the key must be readily available at all times.						
	Based on observation failed to ensure single	ot met as evidenced by: n on 6/23/09, the facility e motion locks on 1 of 3 nroom attached to Bedr	, B				
	Severity: 2 Scope: 2						
Y 445 SS=F	449.229(10) Exit doo	rs		Y 445			
	be equipped with a lo	residential facility must ock which requires a key e unless approved by th r his designee.	/ to				
	Based on observation failed to ensure the fr	ot met as evidenced by: n on 6/23/09, the facility cont and side doors wen that required a key to o	e not				

Bureau of Health Care Quality & Compliance STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: (X3) DATE SURVEY (X2) MULTIPLE CONSTRUCTION AND PLAN OF CORRECTION COMPLETED A. BUILDING B. WING _ NVS358AGC 06/23/2009

NAME OF PROVIDER OR SUPPLIER

STREET ADDRESS, CITY, STATE, ZIP CODE

SAN VICE	NTE HOME CARE	8460 RANCHO DESTINO RD LAS VEGAS, NV 89123					
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Y 445	Continued From page 4		Y 445				
	from the inside.						
	Severity: 2 Scope: 3						
Y 528 SS=C	449.260(1)(c) Activities for Residents		Y 528				
	NAC 449.260 1. The caregivers employed by a residential facility shall: (c) Plan recreational opportunities that are sto the interests and capacities of the resider	suited					
	This Regulation is not met as evidenced by Based on observation on 6/23/09, the facility failed to provide at least 10 hours of activitie each week that were suitable to the interest capacities of the residents.	y es					
	Severity: 1 Scope: 3						
Y 626 SS=F	449.2702(6)(b)(1,2,&3) Restraint Definition		Y 626				
	NAC 449.2702 6. As used in this section: (b) "Restraint" means: (1) A psychopharmacologic drug that is for discipline or convenience and is not requite to treat medical symptoms; (2) A manual method for restricting a resident's freedom of movement or his normaccess to his body; or (3) A device or material or equipment what attached to or adjacent to a resident's body	uired nal iich is					

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(3) Persons do not smoke in those areas

(4) All electrical equipment is inspected for

(5) All oxygen tanks kept in the facility are

(6) The equipment used to administer oxygen

where smoking is prohibited;

defects which may cause sparks.

secured in a stand or to a wall;

stored:

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administered to a resident:

(a) The caregiver responsible for assisting in the

administration of the medication shall: (1) Comply with the order.

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FORM APPROVED Bureau of Health Care Quality & Compliance STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X3) DATE SURVEY (X2) MULTIPLE CONSTRUCTION AND PLAN OF CORRECTION COMPLETED **IDENTIFICATION NUMBER:** A. BUILDING B. WING NVS358AGC 06/23/2009 STREET ADDRESS, CITY, STATE, ZIP CODE NAME OF PROVIDER OR SUPPLIER 8460 RANCHO DESTINO RD SAN VICENTE HOME CARE LAS VEGAS, NV 89123 SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION (X4) ID ID (X5) COMPLETE (EACH DEFICIENCY MUST BE PRECEDED BY FULL (EACH CORRECTIVE ACTION SHOULD BE PREFIX **PREFIX** DATE REGULATORY OR LSC IDENTIFYING INFORMATION) CROSS-REFERENCED TO THE APPROPRIATE TAG TAG DEFICIENCY) Y 878 Y 878 Continued From page 7 This Regulation is not met as evidenced by: Based on record review and interview on 6/23/09, the facility failed to ensure 1 of 10 residents received medications as prescribed (Resident #8). Severity: 2 Scope: 1 Y 885 449.2742(9) Medication / Destruction Y 885 SS=F NAC 449.2742 9. If the medication of a resident is discontinued, the expiration date of the medication of a resident has passed, or a resident who has been discharged from the facility does not claim the medication, an employee of a residential facility shall destroy the medication, by an acceptable method of destruction, in the presence of a witness and note the destruction of the medication in the record maintained pursuant to NAC 449.2744. Flushing contents of vials, bottles or other containers into a toilet shall be deemed to be an acceptable method of destruction of medication. This Regulation is not met as evidenced by: Based on observation and interview on 6/23/09. the facility failed to destroy medications after they were discontinued, had expired or after a resident

had been transferred.

Scope: 3

Severity: 2

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This Regulation is not met as evidenced by:

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SURVEY COMPLETED	
		NVS358AGC		B. WING		06/23/2009	
· · · · · · · · · · · · · · · · · · ·			STREET ADD	RESS, CITY, STA	TE, ZIP CODE	00/2	.0/2000
SAN VICENTE HOME CARE			l	CHO DESTINO S, NV 89123	RD		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FUL REGULATORY OR LSC IDENTIFYING INFORMATIO			ID PREFIX TAG	PROVIDER'S PLAN OF CORE (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE A DEFICIENCY)	SHOULD BE	(X5) COMPLETE DATE
Y 908	failed to ensure the r	iew on 6/23/09, the facil medication record was esidents receiving as ne Resident #9).		Y 908			
Y 920 SS=F	NAC 449.2748	ling, without limitation, a dication, al ed in a locked dry. The distriction or comment that appropriated by a runauthorized Medication for ust be kept in a elefrom other ent who is capable dication to himself may keep his om if the a locked he facility has	iny	Y 920			
	Based on observation failed to keep medical	ot met as evidenced by on on 6/23/09, the facility ations for 6 of 10 reside sident #1, #2, #3, #4, #9	/ ents				

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This Regulation is not met as evidenced by: Based on observation on 6/23/09, the facility failed to keep medications belonging to 10 of 10 residents in their original container (Resident #1, #2, #3, #4, #5, #6, #7, #8, #9 and #10).

(b) Kept in its original container until it is

Severity: 2 Scope: 3

Y 991 449.2756(1)(b) Alzheimer's Fac door alarm SS=F

NAC 449.2756

administered.

- 1. The administrator of a residential facility which provides care to persons with Alzheimer's disease shall ensure that:
- (b) Operational alarms, buzzers, horns or other audible devices which are activated when a door is opened are installed on all doors that may be used to exit the facility.

If deficiencies are cited, an approved plan of correction must be returned within 10 days after receipt of this statement of deficiencies.

Y 991

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failed to ensure knives, matches, scissors, and screw drivers were inaccessible to the residents.

1. The administrator of a residential facility which

Scope: 3

449.2754(1)(g) Alzheimer's Facility

Severity: 2

NAC 449.2756

Y 999

SS=F

Y 999

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